World of Medicare
Web-Based Training Course

Welcome

Welcome to the "World of Medicare" Web-Based Training (WBT) Course.

This WBT course is brought to you by the Centers for Medicare & Medicaid Services' (CMS) Medicare Learning Network® (MLN). The Centers for Medicare & Medicaid Services is the Federal agency responsible for administering the Medicare, Medicaid, Children's Health Insurance Program (CHIP), Health Insurance Portability and Accountability Act of 1996 (HIPAA), Clinical Laboratory Improvement Amendments (CLIA), and several other health-related programs. For more information about CMS and its programs, visit http://www.cms.gov on the CMS website.

This course is the first in a three-part series of web-based training courses designed to teach health care professionals and administrative staff the fundamentals of the Medicare Program.

After completion of this WBT, it is recommended that you also complete the "Your Office in the World of Medicare" WBT, which focuses on Medicare knowledge required by health care professionals and their office personnel, or the "Your Institution in the World of Medicare" WBT, which is designed for providers enrolling in Medicare by completing the Form CMS-855A (or its electronic equivalent), as applicable.

Access these courses at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html on the CMS website.

About the Medicare Learning Network®

Welcome to the Medicare Learning Network® – Your Medicare education and information resource!

The Medicare Learning Network® (MLN) is the home for education, information, and resources for the health care professional community. The MLN provides access to CMS Program information you need, when you need it, so you can focus more on providing care to your patients.

Serving as the umbrella for a variety of CMS education and communication activities, the MLN offers:

1. MLN Educational Products (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html) including MLN Matters® Articles (http://go.cms.gov/MLNMattersArticles)
2. Web-Based Training (WBT) Courses (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html) (many offer Continuing Education credits)
3. MLN Connects® National Provider Calls (http://www.cms.gov/Outreach-and-Education/Outreach/NPC/index.html)
4. MLN Connects® Provider Association Partnerships (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLN-Partnership/index.html)
5. MLN Connects® Provider eNews (http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive.html)
6. Provider electronic mailing lists (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MailingLists_FactSheet.pdf)

About the Medicare Learning Network® (continued)

CMS relies on its Medicare Administrative Contractors (MACs) to assist us in delivering education and information to Medicare FFS providers. These contractors maintain toll-free telephone lines for inquiries; provider self-service options, such as websites and portals; and conduct outreach and education, including interactions with individual providers, group practices, and local professional associations.

If you have questions about the Medicare Program, you should first get in touch with your MAC. To find contact information, please use the Review Contractor Directory - Interactive Map (http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map).

The Medicare Learning Network® (MLN), a registered trademark of the Centers for Medicare & Medicaid Services (CMS), is the brand name for official information health care professionals can trust.

Course Objectives

Upon completion of this course, you should be able to correctly:

- Recognize the basic components and requirements of the Medicare Program;
- Differentiate between Medicare Part A, Part B, Part C, and Part D;
- Identify Medicare beneficiary health insurance options, eligibility, and enrollment;
- Recognize how Medigap and other insurance work with the Medicare Program; and
- Identify the roles that providers, agencies, contractors, and organizations play in implementing the Medicare Program.

Course Content

The "World of Medicare" course consists of job aids, a pre-assessment, course content, review questions, a post-assessment, and a course evaluation. Successful completion of this course requires completion of the pre-assessment, course evaluation, and a cumulative score of 70 percent or higher on the post-assessment.

This course uses cues at various times to provide additional information. The cues are hyperlinks, buttons, rollovers, and pop-up windows. For more information on using these cues, as well as suggested browser settings, click the Help button in the top right corner.

Click the Disclaimers button for Centers for Medicare & Medicaid Services (CMS) disclaimers pertaining to this web-based training course.

Course Content (continued)

The Resources button includes job aids and a glossary of terms defined within this course. It also features a link to a text-only version of this course.

You may click this button to print these materials now or at any time during this course.

After successful completion of this course, you will be given instructions on how to print your certificate.

Lessons

After completion of the pre-assessment, you will be able to access the course lessons. This web-based training is divided into four lessons.

- Lesson One: Medicare Essentials
- Lesson Two: Original Medicare Plan
- Lesson Three: Medicare Advantage Plan
- Lesson Four: Medicare Prescription Drug Plan

Following the lessons, you will complete a post-assessment and course evaluation. Each lesson will take approximately 10-20 minutes to complete.

When taking this course, it does not have to be completed in one session. If you exit the course and return later, the course will open on the last page viewed. Click on the Main Menu button to return to the course main menu.

Lesson Objectives

Upon completion of this lesson, you should be able to correctly:

- Recognize the purpose and history of the Medicare Program;
- Differentiate between Medicare Part A, Part B, Part C, and Part D;
- Select beneficiary Medicare benefit options;
- Identify Medicare beneficiary eligibility and enrollment; and
- Recognize the roles of providers, agencies, contractors, and organizations in administering the Medicare Program.

Estimated completion time for this lesson is 20 minutes.

Introduction to Medicare

The Medicare Program is the nation’s largest health program.

It’s important that individuals and institutions providing Medicare services have a broad understanding of how the program works so that they may identify Medicare benefits, accurately bill Medicare services, and provide care to people with Medicare.

Let’s begin by learning some Medicare basics.

The Medicare Program

Medicare is a Federal health insurance program for individuals:

- Age 65 and older: Individuals age 65 or older who are eligible for Social Security Administration (SSA) or Railroad Retirement Board (RRB) benefits are eligible for Medicare. U.S. citizens and permanent residents of the U.S. may also purchase Medicare;
- Under age 65 with certain disabilities: Disabled individuals under age 65 are eligible for Medicare after receiving disability benefits from the Social Security Administration (SSA) or Railroad Retirement Board (RRB) for 24 months. This 24-month waiting period is waived for people with Amyotrophic Lateral Sclerosis (ALS, or Lou Gehrig’s disease). People with ALS automatically receive Medicare Part A the month their disability benefits begin; and
- Any age who have been determined to have End-Stage Renal Disease (ESRD). ESRD is permanent kidney failure requiring maintenance dialysis or a kidney transplant.

The program is financed by a portion of payroll taxes paid by workers and their employers and by premiums paid by people with Medicare.

History of Medicare

Since the beginning of the 20th century, health care issues have continued to escalate in importance for our nation. There has long been a broad agreement in the United States on the real need for some form of health insurance to alleviate the unpredictable and uneven incidence of medical costs. On the following pages, let’s take a look at the expansion of the Medicare Program throughout the years.

History of Medicare - 1965 / 1966

1965: Title XVIII (18) of the Social Security Act established Medicare. Title XIX (19) established Medicaid. Medicare would provide health care insurance for aged persons. Medicaid would pay for medical assistance for certain individuals and families with low incomes and limited resources. Medicare was a responsibility of the Social Security Administration (SSA), while Federal assistance to the State Medicaid Programs was administered by the Social and Rehabilitation Service

(SRS). SSA and SRS were agencies in the Department of Health, Education, and Welfare (HEW).

1966: The Medicare Program began, establishing health insurance coverage for persons age 65 or older. The program included Medicare Part A and Part B. Part A and Part B are also known as the Original Medicare Plan.

History of Medicare - 1972 / 1977

1972: Congress expanded the Medicare Program to include certain disabled individuals and individuals determined to have End-Stage Renal Disease (ESRD).

1977: The Health Care Financing Administration (HCFA) was created under the Department of Health, Education, and Welfare (HEW) to effectively coordinate Medicare and Medicaid – the two largest health care programs in the United States. In 1980, HEW was divided into the Department of Education and the Department of Health and Human Services (HHS). In 2001, HCFA was renamed the Centers for Medicare & Medicaid Services (CMS).

History of Medicare - 1997 / 2000

1997: Medicare Part C health care options were created for people with Medicare. These options were called Medicare + Choice and generally replaced earlier health care insurance options.

2000: The Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act waived the 24-month waiting period before Medicare entitlement for persons with Amyotrophic Lateral Sclerosis (ALS, or Lou Gehrig's disease) and who are eligible for Social Security disability benefits.

History of Medicare - 2003 / 2006

2003: The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) was signed into law making Medicare a more prevention-focused program offering more affordable health care, prescription drug coverage, expanded health plan options, improved health care access for rural Americans, and preventive care services. As a result of the MMA, Medicare Part C is now known as the Medicare Advantage Plan. The MMA also created Part D, the Medicare Prescription Drug Plan.

2006: The voluntary Medicare Prescription Drug Plan began.

History of Medicare - 2008 / 2010

2008: The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was signed into law improving beneficiary benefits. MIPPA affected mental health coverage under Medicare, improved coverage of preventive care services, implemented new rules regarding Medicare Advantage marketing, and improved Medicare supplemental coverage.

2010: The Affordable Care Act included a series of Medicare reforms that generate savings for Medicare and strengthen the care Medicare beneficiaries receive. The law provided new benefits and services that help keep beneficiaries healthy.

Today, Medicare covers over 50 million Americans who are aged, have certain disabilities, or have been determined to have ESRD. The program helps with the cost of health care but does not cover all medical expenses or the cost of most long-term care.

Parts of Medicare: Part A

Now that we are familiar with how Medicare began, let's review the different types of Medicare coverage.

Part A: Hospital Insurance

Part A helps cover inpatient care in hospitals and inpatient stays in a Skilled Nursing Facility (SNF) (not custodial or long-term care), hospice care services, and home health care services. Some individuals are automatically enrolled in Part A. Others apply to the program when they are eligible.

We'll learn more about beneficiary enrollment later in this lesson.

Parts of Medicare: Part B

Part B: Medical Insurance

Part B is voluntary and designed to supplement Part A coverage. To obtain Part B, an eligible individual must enroll during a specific period and pay required premiums. It helps cover physician services, outpatient care, some preventive

services, and other medical services that Part A doesn't cover. Part B is subject to coverage and limitations.

Part A and Part B are also referred to as the Original Medicare Plan. We'll learn more about the Original Medicare Plan in Lesson Two.

Parts of Medicare: Part C

Part C: Medicare Advantage (MA) Plan

MA Plans provide Part A and Part B benefits. Many MA Plans include prescription drug coverage and may also include other supplemental benefits.

Parts of Medicare: Part D

Part D: Medicare Prescription Drug Plan

Part D is a voluntary plan that helps cover prescription drug costs.

We'll learn more about Medicare Part C and Part D in Lessons Three and Four of this course. For a summary of what each part of Medicare covers, visit the "Medicare & You" handbook at http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf on the Internet.

For more information on the four parts of Medicare, review Chapter 1 of the "Medicare General Information, Eligibility, and Entitlement Manual" at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c01.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Medicare Beneficiary Choices: Original Medicare Plan

People with Medicare are called beneficiaries.

In most cases, beneficiaries receive their Part A and/or Part B Medicare coverage as a Fee-For-Service (FFS) benefit through the Original Medicare Plan. Fee-For-Service Medicare benefits allow beneficiaries to receive care from any health care provider enrolled in Medicare. Generally, a fee is charged to the beneficiary each time a service is rendered by a provider.

To help pay for some of the health care costs that the Original Medicare Plan doesn’t cover, beneficiaries may choose to purchase a Medigap policy. Medicare supplemental health insurance, called Medigap, is sold by private insurance companies and helps pay some of the health care costs that the Original Medicare Plan doesn't cover. Generally, beneficiaries must be enrolled in Medicare Parts A and B in order to purchase a Medigap policy.

They may also choose to enroll in a Medicare Prescription Drug Plan (Medicare Part D) to receive prescription drug benefits. Medicare Prescription Drug Plans provide prescription drug coverage to beneficiaries who elect to enroll in a plan.

More detailed information about the Original Medicare Plan is discussed in Lesson Two of this course.

Medicare Beneficiary Choices: Medicare Advantage (MA) Plan

Individuals can also receive their Part A and Part B Medicare benefits by joining an MA Plan. MA Plans are organizations that contract with CMS provide or arrange for the provision of health care services to Medicare beneficiaries who:

- Are entitled to Part A;
- Enrolled in Part B;
- Do not have End-Stage Renal Disease (there are some exceptions);
- Permanently reside in the service area of the MA Plan; and
- Elect to enroll in an MA Plan.

Remember, MA Plans are also referred to as Medicare Part C.

Many MA Plans will include Medicare prescription drug coverage.

Beneficiaries with an MA Plan do not need a Medigap policy because MA Plans generally cover many of the same benefits that Medigap covers. MA Plans are discussed in detail in Lesson Three.

Medicare Beneficiary Choices: Summary

Original Medicare Plan (Medicare Part A & Part B) OR Medicare Advantage (MA) Plan (Medicare Part C)

STEP 1 Choose Either the Original Medicare Plan or an MA Plan

Original Medicare Plan: Part A (Hospital Insurance) & Part B (Medical Insurance)
OR
Medicare Advantage Plan: Part C – includes BOTH Part A and Part B

Medicare Beneficiary Choices: Summary (continued)

Original Medicare Plan (Medicare Part A & Part B) OR Medicare Advantage (MA) Plan (Medicare Part C)

STEP 2 Decide If They Want Supplemental Coverage
Medigap policies are private supplemental policies that help pay some of the health care costs that the Original Medicare Plan doesn't cover.

Beneficiaries who join an MA Plan usually do not need and cannot purchase a Medigap policy.

Discover More! Beneficiary Coverage: Some beneficiaries receive supplemental coverage through Medicaid, retirement benefits, or other coverage. Others receive prescription drug coverage through retirement benefits or other coverage.

Medicare Beneficiary Choices: Summary (continued)

Original Medicare Plan (Medicare Part A & Part B) OR Medicare Advantage (MA) Plan (Medicare Part C)

STEP 3 Decide If They Want Prescription Drug Coverage
Medicare Prescription Drug Plans provide prescription drug coverage to all beneficiaries enrolled in a prescription drug plan.

Many MA Plans include prescription drug coverage, usually for an extra cost. Generally, if an MA Plan does not include prescription drug coverage, beneficiaries may join a Medicare Prescription Drug Plan.

The Medicare-Medicaid Relationship

Some beneficiaries who have limited incomes and resources may also receive help from the Medicaid Program. People who qualify for both Medicare and Medicaid are called dual eligibles.

For people with full Medicaid coverage, Medicaid supplements Medicare by covering services and supplies available under their State's Medicaid Program. Limited Medicaid benefits are also available to pay for out-of-pocket Medicare cost-sharing expenses for certain other Medicare beneficiaries. Out-of-pocket costs are health care costs that beneficiaries must pay because they are not covered by Medicare or other insurance.

The Medicare-Medicaid Relationship (continued)

Services that are covered by both Medicare and Medicaid will be paid first by Medicare and then by Medicaid, up to the State's payment limit.

For more information on the Medicare-Medicaid relationship, you can find a fact sheet at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf on the Medicare Learning Network® (MLN) products web page.

Medicare Beneficiary Enrollment

Now, let's take a look at Medicare beneficiary enrollment.

Beneficiaries are enrolled in the Medicare Program through an automatic enrollment process or by applying to the program when they are eligible.

Automatic Enrollment

Individuals receiving benefits from the Social Security Administration (SSA) or the Railroad Retirement Board (RRB) will automatically receive Part A starting the first day of the month they turn age 65.

Important note: Citing improvements in the health of older people and increases in average life expectancy, Congress is increasing the normal retirement age. Beginning with people born in 1938 or later, that age will gradually increase until it reaches 67 for people born after 1959. However, even though the full retirement

age for Social Security benefits is no longer 65, Medicare beneficiaries are still eligible for Medicare when they turn 65.

Individuals under age 65 and disabled are automatically entitled to Part A and enrolled in Part B after they receive disability benefits from SSA or RRB for 24 months. People with ALS (Lou Gehrig's disease) automatically get Part A and Part B the month their disability benefits begin. Beneficiaries who don't want Part B have the option of turning it down but may incur penalties when they try to reenroll in Part B at a later date. We'll learn more about these penalties in Lesson Two of this course.

Applying for Medicare

Individuals may apply for Medicare Part A and/or Part B 3 months before their 65th birthday even if they are not receiving Social Security Administration (SSA) or Railroad Retirement Board (RRB) benefits. They may sign up for Medicare even if they don't plan to retire at age 65. Individuals of any age who have been determined to have End-Stage Renal Disease may apply for Medicare when they start maintenance dialysis or receive a kidney transplant.

Medicare Beneficiary Enrollment (continued)

The Social Security Administration (SSA) is responsible for enrolling most people in Medicare. The Railroad Retirement Board (RRB) enrolls railroad retirees in Medicare.

For additional information about the SSA, visit http://www.ssa.gov and, for more information about the RRB, visit https://secure.rrb.gov on the Internet.

Get Connected! Each year, the government sends beneficiaries a handbook to update them on their Medicare coverage choices. To view the handbook, visit http://www.medicare.gov on the Internet.

Part A Eligibility

To be eligible for premium-free Part A, an individual must be insured based on his or her own earnings or those of a spouse, parent, or child. Remember, Part A is hospital insurance that helps cover inpatient care in hospitals and inpatient stays in a Skilled Nursing Facility (SNF) (not custodial or long-term care), hospice care services, and home health care services.

To be insured, the worker must have a specific number of quarters of coverage (QCs). Quarters of coverage are earned through payment of payroll taxes during a person's working years. The exact number of quarters of coverage required to earn premium-free Part A is dependent upon whether a person is filing for Part A on the basis of age, disability, or End-Stage Renal Disease.

For more information on Part A eligibility, visit http://www.medicare.gov on the Internet.

Part A Eligibility (continued)

Health care professionals can determine if a beneficiary has Original Medicare (Part A and/or Part B) benefits by looking at the front of the beneficiary's red, white, and blue Medicare Health Insurance card under the is entitled to section.

Note that beneficiaries with a Medicare Advantage (MA) Plan will have an additional insurance card supplied by the private company administering their plan. Remember, MA Plans provide Part A and Part B benefits. Many plans include prescription drug coverage and may also include other supplemental benefits.

Part B Eligibility

Individuals who are entitled to premium-free Part A (hospital insurance) are eligible for Part B (medical insurance).

Since Part B is a voluntary program, which requires the payment of a monthly premium, those individuals who do not want coverage may refuse enrollment but may incur penalties if they enroll in Part B later.

The Medicare Part B premium is taken out of a beneficiary's monthly Social Security, Railroad Retirement Board (RRB), or Office of Personnel Management payment.

For more information on Medicare eligibility, visit the "Medicare General Information, Eligibility, and Entitlement Manual." Select this manual from the listing of Internet-Only Manuals (IOMs) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

Part B Enrollment Periods

Individuals may enroll in Part B during the following enrollment periods:

- Initial Enrollment Period (IEP);
- General Enrollment Period (GEP); and
- Special Enrollment Period (SEP).

We'll learn more about these enrollment periods on the following pages.

Part B Enrollment Periods (continued)

Initial Enrollment Period (IEP)

Lasts for 7 months starting 3 months before the month of eligibility (at age 65, the 25th month of disability benefit entitlement, or the Part A entitlement date for individuals of any age who have been determined to have ESRD)

General Enrollment Period (GEP)

- For individuals who refused Part B during the IEP or whose Part B coverage was terminated
- January 1 – March 31 of each year
- Coverage is effective July 1

Part B Enrollment Periods (continued)

Special Enrollment Period (SEP)

Individuals who have delayed enrolling in Part B because they or their spouse had group health coverage based on employment can sign up for Part B with no increased premium any time while they have group health plan coverage based on current employment or within 8 months of the end of employer or union health plan coverage.

Note: Individuals disenrolling from a Medicare Advantage (MA) Plan (except a Medicare Savings Account [MSA] Plan) may return to the Original Medicare Plan during the Medicare Advantage Disenrollment Period (MADP) from January 1 – February 14 of each year. We'll learn about the MADP in Lesson Three.

For more information about these enrollment periods, view the "Enrolling in Medicare Part A & Part B" booklet at http://www.medicare.gov/Pubs/pdf/11036.pdf on the Internet. MA Plans (Part C) and Medicare Prescription Drug Plans (Part D) also have similar enrollment periods. We'll learn about these later in this course.

Medicare Providers

Now that you've learned who is eligible for Medicare, let's look at who can provide Medicare services.

The Medicare Program recognizes a broad range of providers and suppliers who furnish the necessary services and supplies to meet the health care needs of people with Medicare.

The term provider will be used generically throughout the remainder of this course when referencing any person or entity enrolled in Medicare who provides health care or services.

Provider Choices

Providers decide how they want to participate in the Medicare Program.

STEP 1 Apply to enroll in Original Medicare

STEP 2 Decide whether to apply to enroll in any MA Plans

To become a Medicare provider and obtain payment from Medicare, providers must enroll in the program by completing an enrollment application. In the enrollment process, CMS collects information about the applying provider and ensures that he or she is qualified and eligible to enroll in the Medicare Program.

Note: Retail pharmacies may enroll in Medicare to provide covered Part B services as a supplier. Pharmacies decide whether to contract with specific MA Plans or Medicare Prescription Drug Plans (Part D).

We'll learn more about provider choices later in this course.

Discover More! Provider Enrollment: When an enrollee in a Medicare Advantage (MA) Private Fee-For-Service (PFFS) Plan obtains services from a provider, although the provider may not have a direct contract with the PFFS Plan, the provider automatically becomes deemed-contracting once the provider furnishes services if:

- The provider is aware in advance of furnishing services, that the person receiving services is enrolled in a PFFS Plan;
- The provider has reasonable access to the plan's terms and conditions of payment; and
- The service provided is covered by the plan.

Medicare Network

Now, let's take a look at the Medicare system's network of agencies, contractors, and organizations that work with providers to furnish health care insurance for Medicare beneficiaries.

Centers for Medicare & Medicaid Services (CMS)

CMS, an agency of the United States Department of Health and Human Services (HHS), oversees the Medicare Program. The agency is headquartered in Baltimore, Maryland.

The SSA and RRB are examples of other agencies involved with administration of the Medicare Program.

Role of CMS

CMS' mission is to ensure effective, up-to-date health care coverage and to promote quality care for people with Medicare.

The agency's primary function is to make certain that its contractors and State agencies properly administer Medicare. It also serves the Medicare Program by:

- Establishing policy for the payment of providers;
- Conducting research of health care management and treatment; and
- Assessing the quality of health care facilities and services.

CMS has regional offices throughout the nation. CMS' regional offices serve as the agency's initial point of contact for beneficiaries, health care providers, and State and local governments. They also perform business functions for the agency including program education, operations, management, and evaluation.

The CMS website, located at http://www.cms.gov, features more information about the agency and Medicare.

Medicare Contractors and Providers

Several types of contractors work with CMS to process Medicare claims from providers.

They include:

- Medicare Administrative Contractors (MACs);
- MA Plan Contractors; and
- Medicare Prescription Drug Plan Contractors.

Throughout this course, we'll learn more about the responsibilities of each type of contractor.

Organizations

Many organizations work with CMS to administer the Medicare Program.

These organizations are located throughout the country and have responsibilities including program integrity, quality improvement, and beneficiary assistance. Some organizations primarily work with Medicare providers, while others mainly work with Medicare beneficiaries.

To learn more about these organizations, view Job Aid A.

Online Resources for Providers

Medicare educational resources are available on the CMS website to assist providers in learning more about the Medicare Program.

It is important that providers use these resources to stay informed of Medicare Program updates due to new health care legislation and policy revisions. These changes may affect the way a provider's business works with Medicare.

For a listing of these resources, view Job Aid B.

Knowledge Review: Medicare Essentials

Test your knowledge.

Select true or false.

1. The Medicare Program serves the aged, certain disabled individuals, and individuals of any age who have been determined to have End-Stage Renal Disease (ESRD).

- A. True
- B. False

The correct answer is A. True.

Knowledge Review: Medicare Essentials (continued)

Test your knowledge.

Select true or false.

2. The Railroad Retirement Board (RRB) oversees the entire Medicare Program.

- A. True
- B. False

The correct answer is B. False.

Knowledge Review: Medicare Essentials (continued)

Test your knowledge.

Select true or false.

3. Medicare beneficiaries can receive their Medicare benefits, Part A and Part B, through the Original Medicare Plan or through a Medicare Advantage (MA) Plan.

- A. True
- B. False

The correct answer is A. True.

Knowledge Review: Medicare Essentials (continued)

Test your knowledge.

Select the correct answer.

4. Medicare Part A is also known as:

- A. Supplemental Insurance
- B. Medical Insurance
- C. Hospital Insurance
- D. Long-Term Care Insurance

The correct answer is C. Hospital Insurance.

Knowledge Review: Medicare Essentials (continued)

Test your knowledge.

Select the correct answer.

5. Choose the type of care that is NOT covered by Medicare Part B:

- A. Doctors' Services
- B. Preventive Services
- C. Outpatient Services
- D. Inpatient Hospital Facility Services

The correct answer is D. Inpatient Hospital Facility Services.

Conclusion: Lesson One

You have now completed Lesson One: Medicare Essentials. Click Main Menu to return to the "World of Medicare" course main menu. Then, select Lesson Two: Original Medicare Plan.

A lesson must be completed by clicking the Main Menu button. Do not click the "X" button in the right-hand corner of the window to exit the WBT course as this will cause you to exit the WBT course and the system will not record your progress.

Lesson Objectives

Upon completion of this lesson, you should be able to correctly:

- Recognize the Original Medicare Plan;
- Identify examples of providers that submit claims for Part A and Part B services;
- Recognize the Original Medicare Plan's covered and non-covered services;
- Identify the role of Medigap; and
- Select Medicare Administrative Contractor (MAC) responsibilities.

Estimated completion time for this lesson is 10 minutes.

Original Medicare Plan

As we learned in Lesson One, the Original Medicare Plan is a Fee-For-Service (FFS) plan that includes both Medicare Part A and Part B coverage. Most people receive their Medicare coverage through the Original Medicare Plan.

Beneficiaries can go to any doctor, supplier, hospital, or other facility that accepts Medicare and is accepting new Medicare beneficiaries.

Provider Types

Examples of providers that submit claims for Part A benefits:

- Hospitals;
- Skilled Nursing Facilities (SNFs);
- Home Health Agencies (HHAs);
- Critical Access Hospitals (CAHs); and
- Hospice agencies.

Providers that submit claims for Part A benefits must contact their local State Survey Agency (SA), which performs initial surveys (inspections) to ascertain

whether a provider meets applicable requirements for participation in the Medicare Program.

Examples of providers that submit claims for Part B benefits:

- Physicians;
- Non-physician practitioners; and
- Suppliers (for example, ambulance, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies [DMEPOS], and clinical labs). DMEPOS is purchased or rented items such as hospital beds, iron lungs, oxygen equipment, seat lift equipment, wheelchairs, and other medically-necessary equipment prescribed by a health care provider to be used in a beneficiary's home which are covered by Medicare.

Providers that submit claims for Part B benefits can be either participating or non-participating providers:

- A participating provider voluntarily signs a term of agreement/contract with Medicare to accept assignment for all services provided to Medicare beneficiaries. This means the provider accepts Medicare's fee schedule amount as payment in full for services rendered.
- A non-participating provider does not sign an agreement. Non-participating providers can still accept assignment of Medicare claims on a case-by-case basis. Note that regardless of participation, some suppliers and practitioner types are required to accept assignment.

For more information on types of providers and provider enrollment, visit http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html on the Centers for Medicare & Medicaid Services (CMS) website.

Covered Services

As defined by law in the Social Security Act, payment for Original Medicare Plan services is contingent upon a determination that:

1. A service meets a benefit category;

2. A service is not specifically excluded from coverage; and

3. The item or service is reasonable and necessary.

Covered Services (continued)

For more information on services covered by Medicare, visit the "Medicare Benefit Policy Manual." Select this manual from the listing of Internet-Only Manuals (IOMs) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the Centers for Medicare & Medicaid Services (CMS) website.

To view TITLE XVIII (18) of the Social Security Act (Health Insurance for the Aged and Disabled), visit http://www.ssa.gov/OP_Home/ssact/title18/1800.htm on the Internet.

What Medicare Part A Covers

Part A covers expenses incurred for medical and other health services including:

- Home health services;
- Hospice care;
- Inpatient hospital stays; and
- Skilled Nursing Facility (SNF) care.

What Medicare Part B Covers

Part B covers expenses incurred for medical and other health services including:

- Physician services, including surgery, consultation, office and institutional calls, and services and supplies furnished incident to a physician's professional service;
- Outpatient hospital services furnished incident to physician's services;
- Outpatient diagnostic services furnished by a hospital;
- Outpatient physical therapy, outpatient occupational therapy, and outpatient speech-language pathology services;
- Diagnostic x-ray tests, laboratory tests, and other diagnostic tests;

- Rental or purchase of durable medical equipment for use in the beneficiary's home;
- Ambulance services;
- Rural Health Clinic (RHC) services;
- Federally Qualified Health Center (FQHC) services;
- Ambulatory Surgical Center (ASC) services; and
- Some preventive services.

What Medicare Part A and Part B Don't Generally Cover

Items and services that Medicare Part A and Part B don't generally cover include:

- Acupuncture;
- Chiropractic services (except to correct a subluxation using manipulation of the spine);
- Cosmetic surgery;
- Custodial care;
- Dental care and dentures;
- Eye care (routine exam), eye refractions, and most eyeglasses;
- Foot care;
- Health care while traveling outside the U.S.;
- Hearing aids and exams for the purpose of fitting a hearing aid;
- Hearing tests that haven't been ordered by a doctor;
- Long-term care;
- Orthopedic shoes (with few exceptions);
- Prescription drugs (most outpatient drugs aren't covered); and
- Syringes or insulin, unless the insulin is used with an insulin pump.

Medicare Part A and Part B Exclusions and Limitations

For more information on Part A and Part B exclusions, visit http://www.ssa.gov/OP_Home/ssact/title18/1862.htm on the Internet.

To learn more about Part B coverage limitations, review Chapter 15 of the "Medicare Benefit Policy Manual" at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf on the CMS website.

Beneficiary Costs

Original Medicare Plan beneficiaries are responsible for the deductible and coinsurance for most services.

The deductible is the amount a beneficiary must pay before Medicare begins to pay for services and supplies covered under the program.

Coinsurance is the share of the cost for services that the beneficiary is responsible for after the deductible is met.

Beneficiaries also may purchase Medicare supplemental health insurance to help pay some of these costs. We'll begin learning more about this type of insurance on the next page.

Medicare Supplemental Health Insurance – Medigap

Now, let's take a look at other types of insurance that work with the Original Medicare Plan.

As we learned earlier, Medigap is Medicare supplemental health insurance sold by private insurance companies that helps pay some of the health care costs that the Original Medicare Plan doesn't cover. Generally, beneficiaries must have Medicare Parts A and B in order to purchase a Medigap policy.

If a beneficiary is enrolled in the Original Medicare Plan and has a Medigap policy, then Medicare and Medigap will each pay its share of covered health care costs. Medigap helps beneficiaries pay for their out-of-pocket costs, as well as other services not covered by Medicare.

How Medigap Works

Medigap only works with the Original Medicare Plan. Medigap policies won't work with Medicare Advantage (MA) Plans or other Medicare plans. Beneficiaries pay a monthly premium for Medigap insurance.

Note: Beneficiaries who have other types of supplemental insurance, such as TRICARE for Life or through an employer or union, might not need to purchase a Medigap policy.

How Medigap Works (continued)

The types of Medigap plans are standardized in accordance with Federal law. Each plan has a different set of benefits and private insurance companies offer the plans of their choice. Each type of Medigap policy offers the same basic benefits, no matter which insurance company sells it. Usually, the only difference between Medigap policies of the same type sold by different companies is the cost.

To view these plans, visit "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" at http://www.medicare.gov/Publications/Pubs/pdf/02110.pdf on the Internet.

Discover More! Medigap Plans: Insurance companies offering Medigap policies are required to sell Medigap Plan A.

Medigap Enrollment

There is a Medigap open enrollment period that begins on the first day of the month in which an individual is both age 65 and enrolled in Medicare Part B. The open enrollment period lasts for 6 months. During this period, beneficiaries can't be denied coverage due to past or present health problems. The open enrollment period is a one-time-only 6-month period when individuals can purchase a Medigap policy. It starts in the first month that a beneficiary is covered under Medicare Part B and is age 65 or older.

After an individual's open enrollment period ends, Medigap insurance companies may use a beneficiary's health history to decide if he/she can buy a Medigap policy and how much he/she may have to pay for the policy.

Individuals may have a guaranteed right to purchase a Medigap policy outside of the open enrollment period. Guaranteed issue rights are rights an individual has in certain situations when insurance companies are required to offer certain Medigap policies even if the individual has health problems.

Individuals may also be able to purchase a Medigap policy during the Medicare Advantage Disenrollment Period (MADP) from January 1 – February 14 of each year; however, coverage is not guaranteed. We'll learn about the MADP in Lesson Three.

In most cases, if beneficiaries drop their Medigap policy, they won't be able to get it back without going through medical underwriting. Medical underwriting is the process that an insurance company uses to decide, based on an individual's medical history, whether or not to take his/her application for insurance, whether or not to add a waiting period for pre-existing conditions (if your State law allows it), and how much to charge the individual for that insurance.

Medigap and Medicare Prescription Drug Plans

Some Medigap policies sold before 2006 included outpatient prescription drug benefits. Beneficiaries who still have this coverage and choose not to sign up for a Medicare Prescription Drug Plan may keep this policy that includes outpatient prescription drug coverage.

Medigap policies currently sold do not include prescription drug coverage. Individuals may enroll in a Medicare Prescription Drug Plan (Part D) for this coverage. We'll learn more about Medicare Prescription Drug Plans in Lesson Four.

Medicare Administrative Contractors (MACs)

A MAC is an organization that has an agreement with CMS to administer the Medicare Program within a specified jurisdiction.

MACs that administer the Original Medicare Plan include:

- Part A/B Medicare Administrative Contractors (A/B MACs);
- Durable Medical Equipment Medicare Administrative Contractors (DME MACs); and
- Home Health and Hospice Medicare Administrative Contractors (HHH MACs).

Get Connected! Find the contact information for your MAC by accessing the Review Contractor Directory - Interactive Map (http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map) on the CMS website.

MAC Responsibilities

MACs are public or private agencies or organizations that have entered into an agreement with CMS to:

- Enroll providers into the Medicare Program;
- Process Medicare claims and make payments to providers;
- Assist in applying safeguards against unnecessary use of covered services;
- Communicate with beneficiaries and the health community; and
- Process appeals of claim denials.

An appeal is a complaint made by a beneficiary or provider who disagrees with a coverage or payment decision on a claim made by a MAC.

Knowledge Review: Original Medicare Plan

Test your knowledge.

Select true or false.

1. Providers submitting claims for Part A benefits include, but are not limited to, hospitals, Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs), and hospices.

    - A. True
    - B. False

The correct answer is A. True.

Knowledge Review: Original Medicare Plan (continued)

Test your knowledge.

Select true or false.

2. Items and services that Medicare does not generally cover include cosmetic surgery, hearing aids, and long-term care.

- A. True
- B. False

The correct answer is A. True.

Knowledge Review: Original Medicare Plan (continued)

Test your knowledge.

Select true or false.

3. A Medicare Administrative Contractor's (MAC) responsibilities include enrolling providers into Medicare Advantage (MA) Plans, processing Medicare claims, and assisting beneficiaries with the appeals process.

- A. True
- B. False

The correct answer is B. False.

Knowledge Review: Original Medicare Plan (continued)

Test your knowledge.

Select the correct answer.

4. Choose the correct statement about Medigap:

- A. If a beneficiary drops their Medigap policy, they can get it back at any time.
- B. To be eligible for Medigap, beneficiaries need only be enrolled in Medicare Part A.
- C. Medigap policies currently sold include prescription drug coverage.
- D. Medigap helps pay some of the health care costs that the Original Medicare Plan doesn't cover.

The correct answer is D. Medigap helps pay some of the health care costs that the Original Medicare Plan doesn't cover.

Conclusion: Lesson Two

You have now completed Lesson Two: Original Medicare Plan.

Click Main Menu to return to the “World of Medicare” course main menu. Then, select Lesson Three: Medicare Advantage Plan.

A lesson must be completed by clicking the Main Menu button. Do not click the “X” button in the right-hand corner of the window to exit the WBT course as this will cause you to exit the WBT course and the system will not record your progress.

Lesson Objectives

Upon completion of this lesson, you should be able to correctly:

- Recognize the purpose of the Medicare Advantage (MA) Plan;
- Identify the types of MA Plans and beneficiary eligibility;
- Recognize the MA Plan provider selection process; and
- Identify MA Plan beneficiary enrollment.

Estimated completion time for this lesson is 15 minutes.

What is a Medicare Advantage (MA) Plan?

An MA Plan, also referred to as Medicare Part C, is a program through which organizations contract with the Centers for Medicare & Medicaid Services (CMS) to provide coverage of health care services to Medicare beneficiaries.

As we learned in Lesson One, Medicare beneficiaries have the option of enrolling in an MA Plan rather than receiving Medicare benefits through the Original Medicare Plan. Remember, the Original Medicare Plan is a Fee-For-Service plan that includes both Medicare Part A and Part B coverage.

What is a Medicare Advantage (MA) Plan? (continued)

In order to join an MA Plan, beneficiaries must:

- Be entitled to Part A (Hospital insurance that helps cover inpatient care in hospitals and inpatient stays in a Skilled Nursing Facility [SNF] [not custodial or long-term care], hospice care services, and home health care services)

enrolled in Part B (Medical insurance that helps cover physician services, outpatient care, and other medical services that Part A doesn't cover. Part B also covers some preventive services);
- Permanently reside in the service area of the MA Plan; and
- Elect to enroll in an MA Plan.

Individuals of any age who have been determined to have End-Stage Renal Disease (ESRD) are generally excluded from enrolling in MA Plans. However, individuals who develop ESRD after MA Plan enrollment may remain enrolled.

For more information, visit the "Medicare Managed Care Manual" at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

How MA Plans Work

Medicare Advantage (MA) Plans provide Part A and Part B Medicare coverage, except hospice. All Medicare-covered services an MA Plan beneficiary receives while in hospice care are paid by the Original Medicare Plan.

In addition to Part A and Part B Medicare coverage, MA Plans may offer extra benefits such as vision, hearing, dental, and/or health and wellness programs and many include prescription drug coverage.

How MA Plans Work (continued)

MA Plans generally have provider networks. Beneficiaries may have to see doctors in the plan's provider network or go to certain hospitals to get services. If they use providers who aren't in the network, they may have to pay the entire cost of the service.

If a beneficiary switches from the Original Medicare Plan to an MA Plan and also has a Medigap policy, he/she won't be able to use the Medigap policy to cover deductibles, copayments, or coinsurance while enrolled in the MA Plan.

Types of MA Plans

There are different types of MA Plans. Learn more about each plan on the following pages.

- Private Fee-For-Service (PFFS) Plan
- Health Maintenance Organization (HMO)
- Medical Savings Account (MSA) Plan
- Preferred Provider Organization (PPO)
- Special Needs Plan (SNP)

Private Fee-For-Service (PFFS) Plan

A PFFS Plan is a type of MA Plan in which beneficiaries may go to any Medicare-approved provider if the provider agrees to accept the plan's terms of payment before treating the beneficiary. PFFS Plans may have extra benefits. The insurance plan, rather than the Medicare Program, decides how much it will pay and what a beneficiary will pay for services received.

Health Maintenance Organization (HMO)

HMO plan beneficiaries can generally only go to doctors, specialists, or hospitals that are part of the plan's network, except in an emergency.

Medical Savings Account (MSA) Plan

MSA Plans combine a high deductible health plan with a Medical Savings Account that beneficiaries can use to manage their health care costs. Once the deductible is met, the plan covers 100 percent of Part A and Part B costs. There are no premiums for MSAs. Beneficiaries must still pay a Part B premium. Prescription drugs are not covered in an MSA Plan, although enrollment in a prescription drug plan is permitted.

Preferred Provider Organization (PPO)

PPOs have network providers, but beneficiaries can also use out-of-network providers for covered services, usually for a higher cost.

Special Needs Plan (SNP)

Membership in SNPs is limited to certain groups of people, such as those in certain institutions (like a nursing home), those eligible for both Medicare and Medicaid, or those with certain chronic or disabling conditions.

MA Plan Contractors

Organizations that seek to offer MA Plans must enter into a contract with Centers for Medicare & Medicaid Services (CMS). Each MA contract is for a period of a calendar year.

MA organization requirements include:

- Meeting minimum enrollment requirements; and
- Following MA Plan marketing guidelines.

MA contracts are automatically renewed from term-to-term unless CMS or the MA organization provides notice of the intent to non-renew or terminate the contract at the end of the current term.

Get Connected! For a complete listing of Medicare Advantage (MA) application procedures and contract requirements, visit Chapter 11 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c11.pdf) of the “Medicare Managed Care Manual.”

MA Provider Selection

Now, let’s take a look at how an MA Plan selects providers. As we just learned, most MA Plans have provider networks that plan members must use for health care services. Providers of MA services must have a provider agreement with CMS permitting them to provide services under Original Medicare.

MA organizations have written policies and procedures when selecting and evaluating health care professionals for inclusion in an MA Plan’s provider network. Certain health care professionals must undergo credentialing to join a provider network.

Credentialing is the review of qualifications and other relevant information pertaining to a health care professional seeking a contract or participation agreement with an MA organization.

Credentialing is required for:

- All physicians who provide services to the MA organization's enrollees, including members of physician groups; and
- All other types of health care professionals who provide services to the MA organization's enrollees, and who are permitted to practice independently under State law.

MA Provider Selection (continued)

If an MA organization declines to include a provider in its network, it must furnish a written notice to the provider of the reason for the decision. If a beneficiary is a member of an MA Plan, the Medicare Administrative Contractor (MAC) cannot process claims for the beneficiary. The beneficiary's claims must be submitted to the MA organization.

For more information on provider enrollment in MA Plans, visit the "Medicare Managed Care Manual" at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

MA Plan Election Periods

Types of MA Plan election periods during which individuals may make enrollment requests include:

- Initial Coverage Election Period (ICEP);
- Annual Election Period (AEP);
- Special Election Periods (SEPs);
- Open Enrollment Period for Institutionalized Individuals (OEPI); and
- Medicare Advantage Disenrollment Period (MADP).

We'll learn more about these election periods on the following pages.

MA Plan Election Periods (continued)

Initial Coverage Election Period (ICEP)

Starts 3 months before the month of eligibility for Medicare Parts A and B and ends on either the last day of the month preceding the effective date for both Parts A and B (for example, for those who deferred their enrollment because of coverage by an employer group health plan) or on the last day of the Part B Initial Enrollment Period (IEP), whichever comes later

Annual Election Period (AEP)

- October 15 – December 7 of each year - Coverage is effective January 1
- Beneficiaries can enroll in, drop, or switch plans during this time
- Also referred to as the Open Enrollment Period in Medicare beneficiary publications and other tools

Discover More! Beneficiary Coverage: Individuals can also enroll in an MA Plan with prescription drug coverage during the Initial Enrollment Period for Part D (IEP for Part D). We'll learn more about this IEP in Lesson Four.

MA Plan Election Periods (continued)

Special Election Periods (SEPs)

Beneficiaries who meet certain conditions may change MA Plans or return to the Original Medicare Plan outside of established enrollment periods. Examples include:

- Disenrolling from employer or union sponsored coverage (including COBRA) to elect an MA Plan: The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a Federal law that may allow individuals to temporarily keep employer or union health coverage after the employment ends or after they lose coverage as a dependent of a covered employee; and
- Enrolling in a 5-Star MA Plan.

Individuals may use this SEP one time each year to enroll in an MA Plan with a Plan Performance Rating of 5 stars for the current calendar year. Plans accept enrollment requests from December 8 of the year prior to the year in which the plan has been granted a 5-star overall rating and November 30 of the year in which the plan has been granted the rating. Coverage is effective the 1st of the month following the month in which the plan receives the enrollment request. Individuals

must live in the plan's service area and meet all requirements to enroll in the plan. Individuals may also use the 5-Star SEP to disenroll from an MA Plan by enrolling in a 5-Star cost plan that is open for enrollment. Medicare cost plans are a type of Medicare health plan available in certain areas of the country that provide the full Medicare benefit package. Payment is based on the reasonable cost of providing services.

Open Enrollment Period for Institutionalized Individuals (OEPI)

- A continuous open enrollment period for MA eligible institutionalized individuals.
- An unlimited number of MA enrollment requests may be made.

Discover More! 5-Star Plans: Medicare uses information from member satisfaction surveys, plans, and health care providers to give overall performance star ratings to plans. A 5-star rating is considered excellent. Visit the Medicare Plan Finder at https://www.medicare.gov/find-a-plan/questions/home.aspx to determine if there is a 5-Star MA Plan in your area.

MA Plan Election Periods (continued)

Medicare Advantage Disenrollment Period (MADP)

- January 1 – February 14 of each year
- Individuals may disenroll from an MA Plan (except a Medicare Savings Account [MSA] Plan) and return to the Original Medicare Plan.
- Effective date of disenrollment request is the 1st of the month following receipt of the request.
- Individuals may not join or switch MA Plans.
- Individuals may be able to purchase a Medigap policy; however, coverage is not guaranteed.
- Individuals disenrolling from an MA Plan (other than an MSA or MA Private Fee-For-Service [PFFS] Plan without drug coverage) may elect a new prescription drug plan regardless of whether they had previous Medicare prescription drug coverage.

For more information about Medicare Advantage Plan enrollment periods, view the "Understanding Medicare Part C & D Enrollment Periods" tip sheet at http://www.medicare.gov/Publications/Pubs/pdf/11219.pdf on the Internet.

MA Plan Costs

Some MA Plans charge beneficiaries a monthly premium. This is in addition to the Part B premium beneficiaries pay to Medicare. Costs vary by plan.

The plan may also have a yearly deductible or additional deductible for some health services, as well as a payment for each doctor's visit or service.

Dual eligibles, or individuals who qualify for both Medicare and Medicaid, may receive help with their MA Plan costs from the Medicaid Program, depending on their level of Medicaid coverage.

MA Plan Benefit Changes

MA Plan benefits may change from year to year. The plan sends an Annual Notice of Change (ANOC) to beneficiaries each fall. This notice has information about any changes in premium, benefits, cost sharing, or service area that will be effective in January of the following year. If the MA Plan covers prescription drugs, the notice will include these changes.

MA Plans also send beneficiaries an Evidence of Coverage (EOC) annually that gives details about what benefits the plan will cover, how much the beneficiary will pay, how to file an appeal, and more.

Knowledge Review: Medicare Advantage (MA) Plan

Test your knowledge.

Select true or false.

1. In addition to Part A and Part B Medicare coverage, MA Plans may offer extra benefits such as vision, hearing, dental and/or health and wellness programs and many include prescription drug coverage.

    - o True
    - o False

The correct answer is A. True.

Knowledge Review: Medicare Advantage (MA) Plan (continued)

Test your knowledge.

Select true or false.

2. MA Plans do not generally have provider networks. MA Plan members may use any provider for their health care services.

- o True
- o False

The correct answer is B. False.

Knowledge Review: Medicare Advantage (MA) Plan (continued)

Test your knowledge.

Select true or false.

3. A Private Fee-For-Service (PFFS) Plan is a type of MA Plan in which beneficiaries may go to any Medicare-approved provider if the provider agrees to accept the plan's terms of payment before treating the beneficiary.

- o True
- o False

The correct answer is A. True.

Conclusion: Lesson Three

You have now completed Lesson Three: Medicare Advantage Plan.

Click Main Menu to return to the "World of Medicare" course main menu. Then, select Lesson Four: Medicare Prescription Drug Plan.

A lesson must be completed by clicking the Main Menu button. Do not click the "X" button in the right-hand corner of the window to exit the WBT course as this will cause you to exit the WBT course and the system will not record your progress.

Lesson Objectives

Upon completion of this lesson, you should be able to correctly:

- Recognize the Medicare Prescription Drug Plan;
- Identify covered drugs and conditions under the Medicare Prescription Drug Plan; and
- Recognize Medicare Prescription Drug Plan beneficiary enrollment.

Estimated completion time for this lesson is 10 minutes.

What is the Medicare Prescription Drug Plan?

The Medicare Prescription Drug Plan, or Medicare Part D, provides prescription drug coverage to all beneficiaries who elect to enroll in a prescription drug plan.

Plans are available through private companies that contract with Medicare to provide prescription drug coverage. Anyone who has Part A and/or Part B and lives in a plan's service area is eligible to join the plan.

How to Get Medicare Prescription Drug Coverage

People with Medicare (who do not already have prescription drug coverage through an employer or union, TRICARE for Life, COBRA, or other means) can obtain prescription drug coverage by either:

1. Joining a Medicare Prescription Drug Plan

OR

2. Selecting a Medicare Advantage (MA) Plan that includes prescription drug coverage

Medicare Prescription Drug Plan Contractors

Part D plan sponsors are nongovernmental entities under contract with the Centers for Medicare & Medicaid Services (CMS) to offer prescription drug benefits.

Each Part D plan must provide current and prospective enrollees the information they need to make informed decisions about their prescription drug coverage on an

annual basis. Information must include the plan's service area, benefits, and the drugs covered by the plan.

For more information on Medicare prescription drug contracting, including access to the application to become a Part D plan sponsor, visit the Prescription Drug Coverage Contracting web page at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/index.html on the CMS website.

Medicare Prescription Drug Plan Choices

Beneficiaries can choose the Medicare Prescription Drug Plan that meets their needs. Plan benefits can vary depending on the following:

- What prescription drugs are covered;
- How much the beneficiary pays; and
- Which pharmacies the beneficiary can use.

Coverage and costs are different for each plan, but all Medicare drug plans must provide at least a standard level of coverage set by Medicare.

Get Connected! To read more about Medicare Prescription Drug Plans, visit http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/index.html on the Centers for Medicare & Medicaid Services (CMS) website.

Covered Drugs

Drugs covered under the Medicare Prescription Drug Plan are available only by prescription, must be approved by the Food and Drug Administration (FDA), and be used and sold in the U.S.

Drugs excluded by law, non-prescription drugs, and drugs that are covered under Medicare Part B are not covered by the Medicare Prescription Drug Plan.

For more detailed information on Medicare prescription drug coverage, visit http://www.medicare.gov on the Internet.

Important Note: Although Medicare Part D plans generally aren't allowed to cover over-the-counter drugs, Part D does cover medical supplies associated with the injection of insulin (and not covered under Medicare Part B) including insulin syringes, needles, alcohol swabs, and gauze.

Covered Conditions

Medicare Prescription Drug Plans must cover most drugs to treat certain conditions, including:

- Cancer medications;
- HIV/AIDS treatments;
- Antidepressants;
- Antipsychotic medications;
- Anticonvulsive treatments for epilepsy and other conditions; and
- Immunosuppressants.

For more information on what Medicare Prescription Drug Plans cover, visit http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/index.html on the CMS website.

Plan Formularies

Each Medicare Prescription Drug Plan has a formulary. A formulary is a list of drugs covered by the plan. The formulary must always meet Medicare's requirements.

Even if a drug is on the plan's formulary, there may be special rules for filling the prescription such as limiting the quantity of a drug a plan covers over a certain period of time for safety and cost reasons. Prior authorization from the plan may also be required before a prescription will be covered to ensure drugs are used correctly and only when medically necessary.

Formularies may not include every Medicare-covered drug but usually cover a similar drug that is safe and effective. Drugs may also have different cost-sharing levels, sometimes called tiers.

A plan's formulary may change during the year because drug therapies change, new drugs are released, and new medical information becomes available. Plans must notify beneficiaries at least 60 days in advance of formulary changes that affect a drug they take.

Plan Formularies (continued)

To find out which plans cover specific prescription drugs, use the Medicare Plan Finder. Visit http://www.medicare.gov and select Find health & drug plans in the Forms, Help, & Resources dropdown menu to locate this tool. You may search for prescription drugs by name or view an alphabetical listing.

Medicare Prescription Drug Plan Enrollment Periods

Generally, there are three types of Part D enrollment periods. Note that the enrollment periods mirror the enrollment periods for Part B and Medicare Advantage (MA) Plans.

- Initial Enrollment Period for Part D (IEP for Part D);
- Annual Coordinated Election Period (AEP); and
- Special Enrollment Periods (SEPs).

We'll learn more about these enrollment periods on the following pages.

Medicare Prescription Drug Plan Enrollment Periods (continued)

Initial Enrollment Period for Part D (IEP for Part D)

- Starts 3 months before the month of Medicare eligibility and lasts for 7 months

Annual Coordinated Election Period (AEP)

- October 15 – December 7 of each year
- Coverage is effective January 1 of the following year
- Beneficiaries can enroll in, drop, or switch plans during this time

Medicare Prescription Drug Plan Enrollment Periods (continued)

Special Enrollment Periods (SEPs)

In certain situations, individuals may be eligible for a SEP. The length of the SEP and the effective date of the change will vary depending on the SEP. Examples include:

- Permanently moving out of plan's service area;
- Entering, residing in, or leaving a long-term care facility (such as a nursing home);
- Qualifying for the extra help with drug plan costs;
- Enrolling in a 5-Star Medicare Prescription Drug Plan; and
- Enrolling in a 5-Star MA-only Private Fee-For-Service (PFFS) Plan or a 5-Star cost plan without Part D coverage.

Individuals should contact the Social Security Administration to determine if they qualify for extra help with their drug plan costs.

Individuals may use this SEP one time each year to enroll in a Medicare Prescription Drug Plan with a Plan Performance Rating of 5 stars for the current calendar year. Plans accept enrollment requests from December 8 of the year prior to the year in which the plan has been granted a 5-star overall rating and November 30 of the year in which the plan has been granted the rating. Coverage is effective the 1st of the month following the month in which the plan receives the enrollment request. Individuals must live in the plan's service area and meet all requirements to enroll in the plan.

Individuals who use the 5-Star SEP to enroll in a 5-Star MA-only PFFS plan or a 5-Star cost plan have a SEP to enroll in a prescription drug plan or in the cost plan's optional supplemental Part D benefit, for which they are eligible. The prescription drug plan selected using this coordinating SEP does not have to be 5-star rated. This SEP begins the month the individual uses the 5-Star SEP to enroll in a MA-only PFFS plan or 5-Star cost plan and continues for two additional months.

Individuals who use the 5-Star SEP to enroll in a MA coordinated care plan are not eligible for this coordinating Part D SEP and must wait until their next valid election period in order to enroll in a plan with Part D coverage. A coordinated care plan is a plan that includes a network of providers that are under contract or arrangement with the organization to deliver the benefit package approved by CMS. Coordinated care plans include plans offered by Health Maintenance Organizations (HMOs) and local or regional Preferred Provider Organizations (PPOs).

Medicare Prescription Drug Plan Enrollment Periods (continued)

Since many MA Plans provide prescription drug coverage, MA beneficiaries usually can't join a Medicare Prescription Drug Plan. If an MA beneficiary, whose plan

includes prescription drug coverage, joins a Medicare Prescription Drug Plan, he/she will be disenrolled from his/her MA Plan and returned to the Original Medicare Plan.

Individuals who disenroll from an MA Plan (other than a Medical Savings Account [MSA] Plan or an MA Private Fee-For-Service [PFFS] Plan without drug coverage) and return to Original Medicare during the Medicare Advantage Disenrollment Period (MADP) from January 1 – February 14 of each year may elect a new Medicare Prescription Drug Plan regardless of whether they had previous Medicare prescription drug coverage.

For more information about Medicare Advantage Plan enrollment periods, view the "Understanding Medicare Part C & D Enrollment Periods" tip sheet at http://www.medicare.gov/Publications/Pubs/pdf/11219.pdf on the Internet.

Late Enrollment

Beneficiaries who don't enroll in a Medicare Prescription Drug Plan when they are first eligible may have to pay a penalty to enroll in a plan later if they don't maintain creditable coverage. Creditable coverage is prescription drug coverage that, on average, is at least as good as Medicare prescription drug coverage.

Most people who wait until after the end of their Initial Enrollment Period (IEP) for Part D to join a plan will have their premiums go up 1 percent for every month they waited to enroll. These individuals will usually have to pay this penalty as long as they have Medicare prescription drug coverage.

Plan Costs

In general, beneficiaries are responsible for paying the following for a Medicare Prescription Drug Plan:

- Monthly premiums;
- Annual deductible;
- Copayments or coinsurance; and
- A small copayment for the rest of the calendar year after they reach a certain out-of-pocket amount.

After a beneficiary has reached a drug plan's standard level of coverage, he/she may have to pay costs for their prescription drugs until they reach a catastrophic coverage level. This period is called the coverage gap.

Plans provide catastrophic coverage for beneficiaries that have an unexpected illness or injury resulting in extremely high drug costs. This coverage pays almost all drug costs after the beneficiary has paid a certain amount of drug costs out-of-pocket during a calendar year.

Closing the Coverage Gap

Beneficiaries reaching the coverage gap receive a discount when buying Part D-covered brand-name or generic prescription drugs. They will receive additional savings each year when reaching the coverage gap until the gap is closed in 2020. Note that the coverage gap does not apply to beneficiaries with limited income and resources who qualify for extra help.

Help With Drug Costs

People with limited income and resources may qualify for help paying their Medicare prescription drug coverage costs.

Individuals with the lowest incomes will pay no premiums or deductibles and have small or no copayments. Those with slightly higher incomes will have no premium or have a reduced premium, have a reduced deductible, and pay a little more out of pocket.

Help With Drug Costs (continued)

If individuals qualify for extra help and don't choose a prescription drug plan, Medicare will automatically enroll them in one.

If an individual qualifies for extra help due to limited income or resources, he/she may not have to pay a late-enrollment penalty, or may get help paying the penalty. This penalty does not apply to people who have creditable coverage.

To find out if they qualify for extra help, individuals should contact the Social Security Administration (SSA).

Knowledge Review: Medicare Prescription Drug Plan

Test your knowledge.

Select true or false.

1. People with Medicare can obtain prescription drug coverage by either joining a Medicare Prescription Drug Plan or selecting an MA Plan that includes prescription drug coverage.

- A. True
- B. False

The correct answer is A. True.

Knowledge Review: Medicare Prescription Drug Plan (continued)

Test your knowledge.

Select true or false.

2. Medicare Prescription Drug Plan benefits can vary regarding which prescription drugs are covered, how much the beneficiary pays, and which pharmacies the beneficiary can use.

- A. True
- B. False

The correct answer is A. True.

Knowledge Review: Medicare Prescription Drug Plan (continued)

Test your knowledge.

Select the correct answer.

3. Select the TRUE statement about Part D plan formularies:

- A. Formularies must include all Medicare Part D-covered drugs.
- B. A formulary is a list of drugs covered by a Medicare Prescription Drug Plan.
- C. All drugs on a plan's formulary always need prior authorization from the plan before they will be covered.
- D. Plans must notify beneficiaries 365 days in advance of formulary changes that affect a drug they take.

The correct answer is B. False.

Conclusion: Lesson Four

You have now completed Lesson Four: Medicare Prescription Drug Plan.

Click Main Menu to return to the “World of Medicare” course main menu.